

DEPARTMENT OF MANAGED HEALTH CARE
TITLE 28

PROPOSED REGULATIONS

For Data Collection and Disclosure Language
For Risk-Bearing Organizations

This proposed action would amend Regulations 1300.75.4, and adopt Regulations 1300.75.4.2 and 1300.75.4.4 of Title 28, California Code of Regulations, to read:

§ 1300.75.4. Definitions

As used in these solvency regulations:

(a) "External party" means the Department of Managed Health Care or its designated agent, which may be an outside entity or person contracted or appointed to fulfill the functions stated in these solvency regulations. Whenever these solvency regulations reference the Department of Managed Health Care, that reference means the Department of Managed Health Care or its designated agent, which may be an outside entity or person contracted by the Department of Managed Health Care to fulfill the stated function.

(b) "Organization" means a risk-bearing organization as defined in subdivision (g) of Health and Safety Code Section 1375.4.

(c) "Plan" means full-service health care service plan, as defined by Health and Safety Code Section 1345(f).

(d) "Risk arrangement" shall include both "risk-sharing arrangement" and "risk-shifting arrangement," which are defined as follows:

(1) "Risk-sharing arrangement" means any compensation arrangement between an organization and a plan under which both the organization and the plan share a risk of financial loss.

(2) "Risk-shifting arrangement" means a contractual arrangement between an organization and a plan under which the plan pays the organization on a fixed, periodic or capitated basis, and the financial risk for the cost of services provided pursuant to the arrangement is assumed by the organization.

(e) "Solvency Regulations" means California Code of Regulations, Title 28, Regulations 1300.75.4 through 1300.75.4.6.

(f) "In a manner that does not adversely affect the integrity of the contract negotiation process" means the disclosure of an organization's financial data in a format that does not

allow a health plan to calculate: (1) an organization's precise profit/loss margins on a per plan basis, (2) or the capitation rates that the organization has negotiated with any other contracting health plan during a prior accounting period.

Authority: Sections 1344 and 1375.4, Health and Safety Code.

Reference: Section 1375.4, Health and Safety Code.

§ 1300.75.4.2. Organization Information

Every contract involving a risk arrangement between a plan and an organization shall require the organization to do all of the following:

(a) Quarterly Financial Survey. For each quarter beginning on or after January 1, 2003, (for an organization that begins its fiscal quarter on January 1, 2003, the first submission is due by May 15, 2003), submit to the Department of Managed Health Care or its designated agent, not more than forty-five (45) days after the close of each quarter of the fiscal year, a quarterly financial survey report in an electronic format to be supplied by the department pursuant to section 1300.41.8 of title 28, containing all of the following:

(1) For organizations serving at least 10,000 lives under all risk arrangements as of December 31, of the preceding calendar year:

(A) Financial survey report (including at least a balance sheet, an income statement, and a statement of cash flows), or comparable financial statements in the case of a nonprofit entity and supporting schedule information (including but not limited to aging of receivable information), reflecting the results of operations for the immediately preceding quarter prepared in accordance with generally accepted accounting principles (GAAP) and the identification of the individual or office in the organization designated to receive public inquiries. Financial survey reports of an organization required pursuant to these rules shall be on a combining basis with an affiliate, if the organization or such affiliate is legally or contractually dependent upon the other for the payment of claims for health care services to enrollees. Any affiliated entity included in this report shall be separately identified. For the purposes of this section, an organization's use of a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating tangible net equity and working capital shall not be construed to automatically create a legal or contractual obligation to pay claims for health care services for enrollees. (B) A statement as to what percentage of claims have been reimbursed, contested, or denied during the quarter by the organization within 45 working days of receipt of the claim, and in accordance with the other requirements of Health and Safety Code Sections 1371 and 1371.35, and in accordance with any other applicable state and federal laws and regulations. If less than 95% of all claims have been reimbursed, contested or denied on a timely basis, the statement shall be accompanied by a report that describes the reasons why the claims-paying process is not meeting the requirements of applicable law, any action taken to correct the deficiency, and any results of that action. This claims payment report is for the purpose of monitoring the financial solvency of the organization and is not intended to change or alter existing state and federal laws and regulations relating to claims payment timeliness.

(C) A statement as to whether or not the organization has estimated and documented, on a monthly basis, its liability for incurred but not reported (IBNR) claims, pursuant to a method specified in Regulation 1300.77.2, and that these estimates are the basis for the quarterly financial survey report submitted under these solvency regulations. If the estimated and documented liability has not met the requirements of Regulation 1300.77.2 in any way, a statement shall be included in the quarterly financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action. An organization failing to estimate and document, on a monthly basis, its liability for incurred but not reported (IBNR) claims or maintaining its books and records on a cash accounting basis shall be deemed to have failed to maintain, at all times, positive tangible net equity and positive working capital as set forth in subsection (D) below.

(D)(i) A statement as to whether or not the organization has at all times during the quarter maintained positive tangible net equity ("TNE"), as defined in Regulation 1300.76(e); and has at all times during the quarter maintained positive working capital, calculated in a manner consistent with generally accepted accounting principles (GAAP). If either the required TNE or the required working capital has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(ii) The organization may reduce its liabilities for purposes of calculating its tangible net equity and working capital in a manner allowed by Health and Safety Code Section 1375.4(b)(1)(B) so long as the sponsoring organization: (1) has filed its audited annual financial statements with the Department of Managed Health Care within 120 days of the end of the sponsoring organization's fiscal year and (2) has submitted a copy of the written guarantee meeting the requirements of Health and Safety Code Section 1375.4(b)(1)(B). For purposes of Health and Safety Code Section 1375.4(b)(1)(B), a sponsoring organization shall have a tangible net equity of at least twice the total of all amounts that it has guaranteed to all persons or entities, or a tangible net equity in an amount approved by the Director of the Department of Managed Health Care, in situations where the organization can demonstrate to the Director's satisfaction that a lesser amount is sufficient. If an organization has a sponsoring organization, the organization shall provide information demonstrating the capacity of the sponsoring organization to guarantee the organization's debts, as well as the nature and scope of the guarantee provided consistent with Health and Safety Code Section 1375.4(b)(1)(B).

(2) For organizations serving less than 10,000 lives under all risk arrangements as of December 31, of the preceding calendar year:

(A) A statement as to what percentage of claims have been reimbursed, contested, or denied during the quarter by the organization within 45 working days of receipt of the claim, and in accordance with the other requirements of Health and Safety Code Sections

1371 and 1371.35, and in accordance with any other applicable state and federal laws and regulations and the identification of the individual in the organization designated to receive public inquiries. If less than 95% of all claims have been reimbursed, contested or denied on a timely basis, the statement shall be accompanied by a report that describes the reasons why the claims-paying process is not meeting the requirements of applicable law, any action taken to correct the deficiency, and any results of that action. This claims payment report is for the purpose of monitoring the financial solvency of the organization and is not intended to change or alter existing state and federal laws and regulations relating to claims payment timeliness.

(B) A statement as to whether or not the organization has estimated and documented, on a monthly basis, its liability for incurred but not reported (IBNR) claims, pursuant to a method specified in Regulation 1300.77.2, and that these estimates are the basis for the quarterly financial survey report submitted under these solvency regulations. If the estimated and documented liability has not met the requirements of Regulation 1300.77.2 in any way, a statement shall be included in the quarterly financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action. An organization failing to estimate and document, on a monthly basis, its liability for incurred but not reported (IBNR) claims or maintaining its books and records on a cash accounting basis shall be deemed to have failed to maintain, at all times, positive tangible net equity and positive working capital as set forth in subsection (C)(i) below.

(C)(i) A statement as to whether or not the organization (1) has at all times during the quarter maintained a positive tangible net equity (TNE), as defined in Regulation 1300.76(e); and (2) has at all times during the quarter maintained a positive level of working capital, calculated in a manner consistent with generally accepted accounting principles (GAAP). If either the required TNE or the required working capital has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(ii) The organization may reduce its liabilities for purposes of calculating its tangible net equity and working capital in a manner allowed by Health and Safety Code Section 1375.4(b)(1)(B) so long as the sponsoring organization: (1) has filed its audited annual financial statements with the Department of Managed Health Care within 120 days of the end of the sponsoring organization's fiscal year and (2) has submitted a copy of the written guarantee meeting the requirements of Health and Safety Code Section 1375.4(b)(1)(B). For purposes of Health and Safety Code Section 1375.4(b)(1)(B), a sponsoring organization shall have a tangible net equity of at least twice the total of all amounts that it has guaranteed to all persons or entities, or a tangible net equity in an amount approved by the Director of the Department of Managed Health Care, in situations where the organization can demonstrate to the Director's satisfaction that a lesser amount is sufficient. If an organization has a sponsoring organization, the

organization shall provide information demonstrating the capacity of the sponsoring organization to guarantee the organization's debts, as well as the nature and scope of the guarantee provided consistent with Health and Safety Code Section 1375.4(b)(1)(B).

(D) In the event an organization serving less than 10,000 covered lives under all risk arrangements fails to satisfactorily demonstrate its compliance with the reviewing or grading criteria, (ii) experiences an event that materially alters the organization's ability to remain compliant with the reviewing or grading criteria, (iii) the Department's review or audit process indicates that the organization may have insufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of section 1300.70(b)(2)(H)(1); or (iv) the Department receives other information from complaints to the HMO Help Center, medical audits and surveys or any other source that indicates the organization may be delaying referrals, authorizations or access to basic health care services based on financial considerations, the organization shall within 30 calendar days of the Department's written request, begin submitting complete quarterly financial survey reports pursuant to section 1300.75.4.2(a)(1).

(b) Annual Financial Survey. (1) Regardless of the number of lives served under all risk arrangements, organizations shall submit to the Department not more than one hundred fifty (150) days after the close of the organization's fiscal year beginning on or after January 1, 2002, and not more than one hundred fifty (150) days after the close of each of the organization's subsequent fiscal years, an annual financial survey report in an electronic format to be supplied by the department pursuant to section 1300.41.8 of title 28, based upon the organization's annual audited financial statement prepared by an independent certified public accountant in accordance with generally accepted auditing standards, and containing all of the following:

(A) Annual financial survey report, based upon the organization's annual audited financial statements (including at least a balance sheet, an income statement, a statement of cash flows, and footnote disclosures), or comparable financial statements in the case of a nonprofit entity, and supporting schedule information, (including but not limited to aging of receivable information and debt maturity information), for the immediately preceding fiscal year, prepared by the independent certified public accountant in accordance with generally accepted accounting principles (GAAP).

Financial survey reports of an organization required pursuant to these rules shall be on a combining basis with an affiliate, if the organization or such affiliate is legally or contractually dependent upon the other for the payment of claims for health care services to enrollees. Any affiliated entity included in the report shall be separately identified. For the purposes of this section, an organization's use of a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating tangible net equity and working capital shall not be construed to automatically create a legal or contractual obligation to pay claims for health care services for enrollees.

When combined financial statements are required by this regulation, the independent accountant's report or opinion must address all the entities included in the combined

financial statements. If the accountant's report or opinion makes reference to the fact that another auditor performed a part of the examination, the organization shall also file the report or opinion issued by the other auditor.

For purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (Division 1, Sections 1 through 99.2, Title 16, California Code of Regulations), shall apply.

(B) Disclose the opinion of the independent certified public accountant indicating whether the organization's annual audited financial statements present fairly, in all material respects, the financial position of the organization, and whether the financial statements were prepared in accordance with generally accepted accounting principles (GAAP). If the opinion is qualified in any way, the survey report shall include an explanation regarding the nature of the qualification.

(2) A statement as to whether or not the organization has estimated and documented, on a monthly basis, its liability for incurred but not reported (IBNR) claims, pursuant to a method specified in Regulation 1300.77.2, and that these estimates are the basis for the financial survey reports submitted under these solvency regulations. If the estimated and documented liability has not met the requirements of Regulation 1300.77.2 in any way, a statement shall be included in the annual financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action. An organization failing to estimate and document, on a monthly basis, its liability for incurred by not reported (IBNR) claims or maintaining its books and records on a cash accounting basis shall be deemed to have failed to maintain, at all times, positive tangible net equity and positive working capital as set forth in subsection (3) below.

(3)(A) A statement as to whether or not the organization has at all times during the year maintained positive tangible net equity (TNE), as defined in Regulation 1300.76(e); and has at all times during the year maintained positive working capital, calculated in a manner consistent with generally accepted accounting principles (GAAP). If either the required TNE or the required working capital has not been maintained at all times, a statement shall be included in the annual financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(B) The organization may reduce its liabilities for purposes of calculating its tangible net equity and working capital in a manner allowed by Health and Safety Code Section 1375.4(b)(1)(B) so long as the sponsoring organization: (1) has filed its audited annual financial statements with the Department of Managed Health Care within 120 days of the end of the sponsoring organization's fiscal year and (2) has submitted a copy of the written guarantee meeting the requirements of Health and Safety Code Section 1375.4(b)(1)(B). For purposes of Health and Safety Code Section 1375.4(b)(1)(B), a sponsoring organization shall have a tangible net equity of at least twice the total of all amounts that it has guaranteed to all persons or entities, or a tangible net equity in an

amount approved by the Director of the Department of Managed Health Care, in situations where the organization can demonstrate to the Director's satisfaction that a lesser amount is sufficient. If an organization has a sponsoring organization, the organization shall provide information demonstrating the capacity of the sponsoring organization to guarantee the organization's debts as well as the nature and scope of the guarantee provided consistent with Health and Safety Code Section 1375.4(b)(1)(B).

(5) A statement as to whether the organization maintains reinsurance and/or professional stop-loss coverage.

(c) Statement of Organization Survey. Submit to the Department of Managed Health Care or its designated agent, a "Statement of Organization," in an electronic format to be filed along with the annual financial survey report, which shall include the following information, as of December 31 of each calendar year prior to the filing:

(1) Name and Address of the Organization;

(2) A Financial and Public Contact Person, with Title, Address, Phone, Fax, and e-mail address;

(3) A list of all Health Plans with which the Organization has risk arrangements;

(4) Whether the Organization is an Independent Practice Association (IPA), Medical Group, Foundation, other entity, or some combination. If the organization is a foundation, identify each and every medical group within the foundation and whether any of those medical groups independently qualifies as a risk-bearing organization as defined in Health and Safety Code Section 1375.4(g);

(5) Whether the Organization is a professional corporation, partnership, not-for-profit corporation, sole proprietor, or other form of business;

(6) A list of the name, address and principal officer of each of the Organization's affiliates as defined in section 1300.45(c)(1) and (2).

(7) Whether the Organization is partially or wholly owned by a hospital or health care system;

(8) A matrix listing all major categories of medical care offered by the Organization, including but not limited to, anesthesiology, cardiology, orthopedics, ophthalmology, oncology, obstetrics/gynecology and radiology, and next to each listed category in the matrix, a disclosure of the compensation model (salary, fee-for-service, capitation, other) used by the organization to compensate the majority of providers of that category of care;

(9) An approximation of the Number of Enrollees served by the Organization under a risk arrangement, pursuant to a list of ranges developed by the Department;

(10) Any Management Services Organization (MSO) that the organization contracts with for administrative services;

(11) The total number of contracted Physicians in employment and/or contractual arrangements with the Organization;

(12) Disclosure by California County or Counties of the Organization's primary service area (excluding out-of-area tertiary facilities and providers);

(13) Any other information, which the Director deems reasonable and necessary to understand the operational structure and finances of the Organization.

(d) Submit a written verification for each report made under paragraphs (a), (b), and (c) of this section stating that the report is true and correct to the best knowledge and belief of a principal officer of the Organization, and signed by a principal officer, as defined by regulation 1300.45(o) of Title 28 of the California Code of Regulations.

(e) Notify the Department of Managed Health Care or its designated agent no later than five (5) business days from discovering that the Organization has experienced any event that materially alters its financial situation, or threatens its solvency.

(f) Permit the Department of Managed Health Care or its designated agent to make any examination that it deems reasonable and necessary to implement Health and Safety Code Section 1375.4, and provide to the Department, upon request, any books or records that the Department deems relevant to implementing this section, for inspection and copying.

Authority: Sections 1344 and 1375.4, Health and Safety Code.

Reference: Section 1375.4, Health and Safety Code.

§ 1300.75.4.4. Confidentiality

Financial and other records produced, disclosed, or otherwise made available pursuant to Health and Safety Code Section 1375.4, and to these solvency regulations shall be received and maintained by the Department on a confidential basis and protected from public disclosure, except that:

(a) within 120 days following each reporting period due date, the Director will make the following information available for public inspection:

(1) A list of all provider organizations currently identified as risk-bearing organizations;

(2) A list of all risk-bearing organizations that have submitted substantially complete financial survey forms, if required, and whether the risk-bearing organization's submission reflects that the minimum criteria for grading or reviewing the financial solvency of the risk-bearing organization has been met;

(3) All information contained in the quarterly and annual survey submissions of risk-bearing organizations shall be deemed public information except that statements relating to any unilateral remedial action implemented by an organization and footnote submissions from an organization's audited financial statement shall be received and maintained by the Department on a confidential basis and protected from public disclosure;

(4) All information contained in the Statement of Organization of risk-bearing organizations shall be deemed public information; and

(5) All information contained in the quarterly and annual submissions of health plans shall be deemed public information except that information relating to the number of covered lives serviced by contracting organizations shall be received and maintained by the Department on a confidential basis and protected from public disclosure.

(b) Notwithstanding the disclosures enumerated in paragraph (a) above, an organization may petition the Director for confidential treatment of specific portions of a financial survey submission upon demonstration that an adverse affect on the integrity of the contract negotiation process between the organization and one of its contracting health plans will likely result if the financial information is made available to the public. Requests for confidential treatment of any information contained in a financial survey submission or a Statement of Organization must be filed with the information submitted and meet the following requirements:

(1) The information intended to remain confidential must be filed separately from the remaining parts of the financial survey submission and marked "Confidential Treatment Requested."

(2) The person filing the financial survey submission and requesting confidential treatment must sign the request and provide the following information: (i) a statement identifying the information that is the subject of the request and the financial survey submission relating thereto; (ii) a statement of the specific grounds upon which the request is made, including a statement explaining how disclosure will adversely impact the organization's contract negotiations with its contracting health plan(s) if the information is disclosed through the public records of the Department; and (iii) a statement specifying the time for which confidential treatment of the information is necessary, and the basis for such conclusion.

(c) Requests for confidentiality will be available for public inspection. Therefore, the request for confidentiality should not contain information that is itself confidential.

(d) If a request for confidential treatment is granted, the person making such request will be notified in writing, the information will be marked "confidential" and kept separate from the public file, and the application or report will be noted with the following legend: "Additional portions of this financial survey submission have been granted confidential treatment."

(e) Material for which confidential treatment is requested shall not be deemed filed unless the request is granted, and may be withdrawn by the organization if the request is denied, unless (1) the Director has already taken an official action in reliance on such information prior to receiving the request for confidential treatment; or (2) the Director determines that the withdrawal of such information is otherwise contrary to the public interest. If withdrawn, the organization's financial survey submission shall be deemed not substantially complete.

(f) Information held confidential pursuant to this section may be disclosed by the Director, at any time and in the Director's sole discretion, whether on the Director's own motion or upon the request of any person, under the following circumstances:

(1) To other local, state, or federal regulatory or law-enforcement agencies, in accordance with the law;

(2) When necessary or appropriate in any proceeding or investigation pursuant to the law under which the information was filed;

(3) Upon a determination by the Director that the private and/or public interest in disclosing such information outweighs the public interest in non-disclosure; or

(4) Upon a determination by the Director that the justifications for the confidential treatment no longer exist.

If the Director determines to disclose information previously designated as confidential and concludes that the disclosure of such information is necessary and urgent, or that it is impractical under the circumstances to give notice to the person who requested confidential treatment of the information, the information may be disclosed without notice. Otherwise, the person who requested confidential treatment of such information shall be given notice that the release of such information is under consideration and the reasons therefore. Thereafter, the person so notified will be given not more than five business days to explain why the need and justification for continued confidentiality exists.

(g) A request to inspect information designated confidential pursuant to this section shall be in writing, state the justification for the request, and be signed by the person making the request. As soon as practical after the receipt of a request to inspect information designated as confidential, the Department will forward a copy of the request to the person who requested confidential treatment of the financial survey information in accordance with subsection (f) above. An individual may petition the Director for confidential treatment of a request for inspection of confidential information, in accordance with subsection (b) above.

(h) Nothing contained herein shall be interpreted as affording any person a right to withdraw information received by the Director, except as provided in subsection (e).

Authority: Sections 1344 , 1346, and 1375.4, Health and Safety Code.
Reference: Sections 1375.4 .